http://ijhpm.com
Int J Health Policy Manag 2015, 4(11), 793–794

doi 10.15171/ijhpm.2015.179

IJHPM International Journal of Health Policy and Management

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Health Management Mentoring for Health Systems Strengthening: A Response to Recent Commentaries

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Citation: Moon TD, Edwards LJ, Vermund SH. Health management mentoring for health systems strengthening: a response to recent commentaries. *Int J Health Policy Manag.* 2015;4(11):793-794. doi:10.15171/ijhpm.2015.179

Received: 20 September 2015, Accepted: 30 September 2015, ePublished: 2 October 2015

We would like to thank Lapão[1] and Schwarcz et al[2] for their thoughtful additions related to our article "*Implementation of a health management mentoring program: Year-1 evaluation of its impact on health system strengthening in Zambézia Province, Mozambique,*"[3] and for sharing their practical lessons and insights into the state of health system strengthening activities. In our article, we described a health management mentoring strategy and suggested results in district health system functioning after its first year of implementation. This program, implemented as part of a vertically financed, HIV-specific package of activities under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), focused on improving holistic fiscal and administrative operations in 10 districts of Zambézia Province, Mozambique. Underpinning this initiative was the assumption that improvements in overall health system functioning would lead to better disease-specific outcomes for patients. We reported changes over time in 4 indicators of the district health systems administrative departments: accounting, human resources, monitoring and evaluation, and transportation management. Lapão[1] and Schwarcz et al[2] described additional field-based initiatives aimed at improving health management within low- and middle-income countries (LMICs), with both authors highlighting the need for rigorous methods to evaluate such programs and share lessons learned. We agree that robust, systematic evaluation is necessary to understand the true impact of our interventions and clarify *what it is exactly* that the global health community is trying to achieve through activities deemed "health system strengthening."

In 2007, the World Health Organization (WHO) released a framework for action, stating "*it is impossible to achieve national and international goals - including the Millennium Development Goals - without greater and more effective investment in health systems and services.*" This framework established six building blocks aimed at promoting a common understanding of health system strengthening.[4] With the growth of global health initiatives such as PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the Global Alliance for Vaccines and Immunizations (GAVI), the Roll Back Malaria (RBM) Partnership, and the Global Network for Neglected Tropical Diseases, among others, health system strengthening as an idea is now embedded as a targeted objective within every major global health and development initiative currently underway.[5] Despite what would appear to be a clear area of prioritization, the concept of health system (or systems) strengthening remains loosely defined, under-resourced, and lacking focus. Consequently, almost any health-related capacity building activity, regardless of size and scope, can be labeled as "health system strengthening." Such sweeping language makes measuring impact a challenge, and funders, like PEPFAR, may be unenthusiastic to invest when outcome metrics are unclear.

The alternative, taking a reductionist view of health systems, can also lead to precarious consequences. By too narrowly focusing on any one of the six core building blocks of health systems while ignoring the complexities of the interrelationships between them, one can be lulled into believing that improvements achieved through component-specific interventions are improving the health system as a whole, when in fact, the opposite may be true.[6,7]

Disease-specific strategies implemented through approaches lacking alignment with holistic health system strengthening efforts run the risk of displacing core activities within the health sector.[7,8] For example, it is difficult to argue against goals of increasing vaccination uptake through mass campaigns, promoting community-based HIV testing, or distributing insecticide treated bed nets. However, when human resources are limited and the same health workers are expected to implement each of these activities, there is risk of interrupting the routine functions of the health system. Similarly, workforce capacity building activities through training on a particular topic area or method is often thought of as a "magic bullet" and serves as the fundamental strategy for a majority of health system strengthening interventions. One or two trainings per year by health workers on a specific area could be manageable; however, when trainings are encouraged by numerous disease-specific programs (HIV, tuberculosis, malaria, immunizations, etc.), health workers are diverted from their regular duties.

Many health system strengthening activities take on a vertically focused, disease-specific model to meet the demands of donors seeking accountable means for achieving certain outcomes. Consequently, short- and long-term goals are in a constant state of tension. Albeit slower and more difficult to implement, broader and more holistic approaches to disease-specific interventions can target the root causes of health system weakness. Such approaches to comprehensive health system reform require diligence, patience, and a measure of creative thinking, as weaknesses at one level may be a direct

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or indirect consequence of problems at another level. For example, our study found that late payment of salaries and a lack of clear, established career development plans for health workers likely contributed to low motivation, high turn-over, and thus inferior quality of clinical services. Another example is that of drug, vaccine, or test kit "stock outs," which can cause a motivated patient to be denied essential treatments due to shortages in a poorly functioning supply chain.

Our health management mentoring strategy was implemented as one component of a "vertical," disease-specific (PEPFAR) package of support and technical assistance. We approached program design with three important caveats: (1) Outcomes would not be exclusively focused on interim targets of HIV care and treatment established by PEPFAR, but rather would have sustainable, long-term goals; (2) There would not be fast enough capacity-building to meet PEPFAR's objective to transition fiscal and managerial responsibilities to local control without improving the overall functioning of district health systems; and (3) Once district financial and administrative capacities were strengthened, these sites would be prepared to benefit from alternative managerial strategies, such as performance-based financing, which have proven effective elsewhere and could contribute more directly to short-term PEPFAR targets.[9,10] While we feel our design strategy was grounded in a broad, long-term, holistic approach to health system strengthening, its lack of a HIV-specific focus has placed it in continual threat of being defunded as PEPFAR decision-makers struggle with their priority to meet short-term HIV care and treatment scale-up numbers.

The call to rethink global health strategies in ways that lead to sustainable and system-wide effects is not new. As far back as the Declaration of Alma Ata in 1978, building resilient and capable "horizontal" health systems has been a global priority.[11] Yet a unifying, agreed-upon consensus for what defines health system strengthening, guiding how we set funding priorities to capacitate LMICs, continues to elude us.[12] We appreciate the critical eye vis-à-vis mentoring by Lapão[1] and Schwarcz et al.[2]

Ethical issues

Not applicable.

Competing interests

Authors declare that they have no competing interests.

Authors' contributions

All authors contributed equally to the development and revision of this paper.

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